STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155668	A. BUILDING _____ B. WING _____	02/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE RETIREMENT HOME	4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 31, February 1, 2, 3, 7, 2011 Facility number: 001144 Provider number: 155668 AIM number: 200256980 Survey team: Donna Groan, RN, TC Avona Connell, RN Gloria Reisert, MSW Census bed type: SNF: 52 SNF/NF: 69 Residential: 04 Total: 125 Census payor type: Medicare: 26 Medicaid: 44 Other: 55 Total: 125 Sample: 24 Residential sample: 5 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 2/10/11 by Suzanne Williams, RN	F 000	This plan of correction constitutes Mercy Providence Retirement Home's credible allegation of compliance for all cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state and federal statutes, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

Approved 2/24/11 SW

RECEIVED
FEB 22 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2-22-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure furniture, and fixtures were clean and in good repair during environmental observations on 2 of 5 survey days. The deficient practice affected 3 of 14 rooms on the 300 hall; 2 of 14 rooms on 200 hall; 2 of 12 rooms on the 400 hall, 2 of 9 rooms on the 600 hall, 2 of 9 rooms on the 700 hall; 3 of 13 rooms on the 800, hall; and 4 of 13 rooms on the 900 hall and 11 residents who utilize facility chairs in the South dining room. Findings include: On 01/31/11 at 1:43 p.m., in the presence of the Director of Dietary, the following was observed: 1. In the South dining room the wood frames of 13 of 13 chairs were soiled with heavy dust that rolled up when swiped with the fingers. On 02/03/11 between the hours of 12:46 p.m. and 1:06 p.m., accompanied by the Administrator the following was observed. 2. Room 212-The bed frame was soiled with heavy dust. 3. The wood frames of chairs outside of room 213 were soiled with dust. 4. Room 305-The bed frames were soiled with heavy dust.	F 253	**1)What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice?** The chairs in the South dining room have been cleaned and dust removed. The bed frame is Room 212 has been cleaned and dust removed. The wood frames of the chairs outside of room 212 have been cleaned and dust removed. The bed frames in Room 305, 403 804 (bed 1 and bed 2), 808, 709, 703, 910 (bed 1 and bed 2), 909 and 912(bed 1 and bed 2) have been cleaned and dust removed. The bed frames and overbed lights in room 402, 607, 608, 809 and 913 have been cleaned and dust removed. The bed frame and wood chair frame in Room 308 and 310 have been cleaned and dust removed.	

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F 253	Continued From page 2 5. Room 308-The bed frame and wood chair frame was soiled with dust. 6. Room 310-The bed frame and wood chair frame was soiled with dust. 7. Room 402-The frame of one bed and one over the bed light was soiled with dust. 8. Room 403-The bed frames were soiled with heavy dust. 9. Room 607-The frame of one bed and one over the bed light was soiled with heavy dust. 10. Room 608-The frame of one bed and one over the bed light was soiled with heavy dust. 12. Room 804-The frames of both beds were soiled with heavy dust. 12. Room 808- The frame of one bed was soiled with heavy dust. 13. Room 809-The frames of two beds and one over the bed light was soiled with heavy dust. 14. Room 709-One bed frame was soiled with a white powdery substance. 15. Room 703-The frame of one bed was soiled with heavy dust. 16. Room 910-The frames of both beds were soiled with heavy dust. 17. Room 909-The frames of one bed was soiled with heavy dust.	F 253	**2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.** Housekeeping Director/Designee will complete an audit of all facility bed frames, dining room chairs, resident room chairs and overbed lights to assure no other areas are affected with heavy dust. **3)What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Housekeeping staff will be in-serviced on cleaning over-bed lights on a daily basis, dining rooms are to be dusted twice a month, chairs in resident rooms are to be dusted twice a month and bed frames are to dusted twice a month. Housekeeping Supervisor/Designee will complete an audit for dust to bed frames, dining room chairs, resident room chairs and overbed lights monthly for three months, then quarterly for the remainder of the year. Findings will be reported to the QA committee.	

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F 253	Continued From page 3 18. Room 912- The frames of both beds were soiled with heavy dust. 19. Room 913- The frame of one bed and one over the bed light was soiled with heavy dust. 20. In interview with the Director of Housekeeping on 02/03/11 at 12:45 p.m., she indicated bed frames are cleaned when the rooms are deep cleaned monthly. She provided a copy of the "Checklist For Deep Cleaning Rooms" at 1:30 p.m., on this same date. The checklist included under the section for "Bedroom" Overbed light and under section ""Bed", Frame. 3.1-19(f)	F 253	**4)How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Housekeeping Supervisor/Designee will complete and audit for dust to bed frames, dining room chairs, resident room chairs and overbed lights monthly for three months, then quarterly for the remainder of the year. Findings will be reported to the QA committee.	3/9/11
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272	**1)What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice?** Upon readmission to the facility Resident #78 will be assessed after each return from dialysis treatment to check shunt site and condition along with vital signs and check fro thrill/bruit of shunt.	

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F 272	Continued From page 4 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assess a resident after each return from dialysis treatment to check for thrill/bruit [how well blood was flowing through shunt], vital signs, and shunt site condition. This deficient practice affected 1 of 1 dialysis resident reviewed for dialysis care in a sample of 24 residents. (Resident #78) Finding includes: Review of the clinical record for Resident #78 on 2/2/2011 at 11:50 a.m., indicated the resident was re-admitted to the facility from the hospital and had diagnoses which included, but were not limited to, end stage renal disease, chronic renal insufficiency, and chronic ischemic heart disease. Among the admission orders was an order for hemodialysis three times a week. Nursing notes between 1/19/2011 and 1/31/2011 failed to locate documentation of an assessment of the resident after she returned from dialysis	F 272	**2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.** One other resident is receiving dialysis at this time and will have assessments completed after each return from dialysis treatment as stated. **3)What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed staff will be in-serviced on assessment of a resident upon return from dialysis which will include documenting the thrill/bruit, vital signs and shunt site condition. Director of Nursing/Designee will complete a weekly audit for one month, monthly for three months and then quarterly for the remainder of the year for assessment documentation after residents return from dialysis. Findings will be reported to the QA committee.	

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F 272	Continued From page 5 each time, including the appearance of her shunt site (i.e. bandage dry or any signs of bleeding), vital signs, and whether a thrill and bruit were present. During an interview with LPN #3 and the MDS [Minimum Data Set] assessment coordinator on 2/2/2011 at 12:32 p.m., they indicated there should be documentation in the nursing notes each time the resident returned from dialysis on what the site looked and sounded like and vital signs including a return weight. During an interview with the Director of Nursing [DoN] on 2/2/2011 at 2:33 p.m., she indicated she did not have a policy and procedure for care of a dialysis resident, but her expectations were for staff to be documenting vital signs, mental status, and condition of shunt site each time the resident returned from dialysis. 3.1-31(a)	F 272	**4)How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Director of Nursing/Designee will complete a weekly audit for one month, monthly for three months and then quarterly for the remainder of the year for assessment documentation after resident return from dialysis. Findings will be reported to the QA committee.	3/9/11
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	**1)What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice?** A care plan will be implemented for Resident#78 to address the resident's dialysis needs, shunt site and care, vital signs, thrill/bruit of shunt prior to and after returning each time from the hemodialysis center.	

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F 279	Continued From page 6 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a care plan which addressed the needs of a dialysis resident, shunt site and care, vital signs, thrill/bruit of shunt [how well blood was flowing through shunt] of a resident prior to and after returning each time from the hemodialysis center. This deficient practice affected 1 of 1 resident receiving hemodialysis in a sample of 24 residents. (Resident #78) Finding includes: Review of the clinical record for Resident #78 on 2/2/2011 at 11:50 a.m., indicated the resident was re-admitted to the facility from the hospital and had diagnoses which included, but were not limited to, end stage renal disease, chronic renal insufficiency, and chronic ischemic heart disease. Among the admission orders was an order for hemodialysis three times a week. Nursing notes between 1/19/2011 and 1/31/2011 failed to locate documentation of an assessment of the resident after she returned from dialysis each time, including the appearance of her shunt site (i.e. bandage dry or any signs of bleeding), vital signs, and whether a thrill and bruit were present.	F 279	**2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.** One other resident is receiving dialysis at this time and has the potential to be affected by this practice. A care plan will be implemented upon admission to the facility for this resident. **3)What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed staff will be in-serviced on the need to care plan the needs of any resident receiving dialysis to include shunt site and care, vital signs and thrill/bruit of a resident prior to and after returning each time from the hemodialysis center. Director of Nursing/Designee will audit monthly for three months and then quarterly for the remainder of the year to ensure development of a care plan of those residents receiving dialysis. Findings will be reported to the QA committee.	

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F 279	Continued From page 7 Review of the care plans for Resident #78 failed to locate a care plan which addressed the special needs of a dialysis resident, including shunt site and care (i.e. no needle sticks or blood pressure in arm with shunt, absence or presence of blood at site), thrill and bruit of shunt, and vital signs. During an interview with MDS [Minimum Data Set] assessment coordinator on 2/2/2011 at 12:32 p.m., she indicated nursing would do a preliminary care plan on dialysis and shunt care and she would do the admission assessments. She also indicated that by the first care plan meeting, she would update the care plan with any additional information. During an interview with the Director of Nursing [DoN] on 2/2/2011 at 12:32 p.m., she indicated there should have been a care plan to address how to care for the dialysis resident. 3.1-35(a) 3.1-35(b)(1)	F 279	**4)How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Director of Nursing/Designee will audit monthly for three months and then quarterly for the remainder of the year to ensure the development of a care plan of those residents receiving dialysis. Findings will be reported to the QA committee.	3/9/11
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by:	F 322	**1)What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice?** Resident #69 is receiving all medications administered through the G-tube per facility policy.	

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F 322	Continued From page 8 Based on observation, interview and record review, the facility failed to ensure medications given through a gastrostomy tube were administered according to facility policy for 1 of 1 resident observed receiving medications via G tube during the medication pass. (Resident #69) Findings include: During the medication pass on 2/2/11 between 8:25 a.m. and 9 a.m., the following was observed: LPN #4 was observed giving the following medications to Resident #69. Hydrocodone (pain medication) 4 mg (milligram) PGT (per gastrostomy tube) q. (every) 2 hours; Calcium 500 mg w/vit d 200 IU (strengthen bone) give 1 tablet via g-tube 2 times a day; Magnesium Oxide (stimulates peristalsis and bowel evacuation) 400 mg tablet. Give 2 tablets (800 mg) via g-tube daily; Metoprolol tartrate (to treat high blood pressure) 25 mg tablet give 1 tablet via g-tube 2 times a day." All of the medications were crushed as per Physician's Order dated 1/30/11. LPN #4 disconnected the tube feed, checked placement and residual, and began by giving the 250 cc (cubic centimeters) Normal Saline flush. She then gave 30 cc flush and poured all of the crushed medicines into the syringe adding more saline. The crushed medications had not been dissolved in water prior to administration. She then used the piston to push the medications through the g-tube and flushed with normal saline. Review of the policy and procedure for Tube Feeding - Enternal (sic) Nutrition, dated 10/8/10, provided by the Director of Nursing on 2/2/11 at	F 322	**2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.** Two other residents in the facility have the potential to be affected by this practice. The Director of Nursing/Designee will complete medication pass audit on these residents receiving medications through a G-tube to ensure the medications are being administered according to facility policy. **3)What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed staff/Qualified Medication Techs will be in-serviced on facility policy on giving medications through a gastrostomy tube. Policy on administration of medications through a gastrostomy tube has been reviewed and revised.	

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F 322	Continued From page 9 9:35 a.m., included, but was not limited to "Medications 1. C. If crushed tablets are administered, crush the tablet to a fine powder and mix in tap water..." On 2/2/11 at 3:30 p.m., in interview with the Director of Nursing, when queried about giving medications through a g-tube, she indicated she would have to review the policy.	F 322	Director of Nursing/Designee will complete medication administration audits on G-tube residents monthly for three months and then quarterly for the remainder of the year. Findings will be reported to the QA committee. **4)How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Director of Nursing/Designee will complete medication administration audits on G-tube residents monthly for three months and then quarterly for the remainder of they year. Findings will be reported to the QA committee.	3/9/11
F 323 SS=D	3.1-44(a)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate supervision for a cognitively impaired resident (Resident #73) who was at risk for falls, and had two falls within 2 hours and 40 minutes, for 1 of 7 residents reviewed for falls in a sample of 24. Findings include: The clinical record for Resident #73 was reviewed on 2/2/11 at 11:40 a.m. The resident diagnoses included, but were not limited to, hypertension, acute kidney failure, and dementia.	F323	**1)What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice?**	

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F 323	Continued From page 10 Nurse's Notes included, but were not limited to: 1/3/11 8:45 p.m. "Rm (room) mate came out in hall and informed staff of Res. (resident) on floor. Found Res. on buttocks propped up with hands beside bed. Res. stated 'I was trying to shut the door...Res. had non-skid socks on - stated 'I just slid down.'" 1/3/11 11:25 p.m."V/S (vital signs) 169/82, 97.9, 78, 93% (oxygen saturation) Nurse called to res. room per CNA (certified nurse assistant). CNA was outside of room and heard a loud noise, upon entering room res. was noted sitting on the floor with her head back against the wall (where the thermostat is) between side A + B of the room. Res. stated 'No body answered the phone, I was trying to answer the phone it might be [named].' Res. very confused doesn't know where she is, thinks she's in her mother's room. Unable to reorientate. Supervisor notified. Res obtained 1.0 cm (centimeter) x 0.2 cm S/T (skin/tear) to L (left) elbow. No other injuries noted. Res. assisted to bathroom + back to bed without incident. Call light with in reach. Will cont. (continue) to monitor." The risk for falls care plan dated 6/2/2010 included, but was not limited to "Focus: Risk for falls R/T weakness, decreased endurance, impaired judgement, cognitive impairment: Interventions: Assist with toileting as needed., Bed wheels locked & bed in lowest position., Enabling devices as needed., Keep call light & frequently used items within reach when in room., Monitor for changes in safety & intervene as necessary., Monitor for S/S (signs/symptoms) of side effects to medications., Non skid footwear., Pathways well lit & clutter free., Restorative/Therapy as indicated., Encouraged	F 323	Unable to correct for Resident #73 but the care plan for falls of Resident#73 will be reviewed and updated as needed. **2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.** Director of Nursing/Designee will complete a falls assessment and review of care plan on all residents who have been identified to be a risk for falls for appropriate interventions. **3)What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All Licensed staff will be in-serviced on assessing residents for risk for falls, putting new interventions into place after each fall and updating care plans accordingly.	

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PROVIDENCE RETIREMENT HOME	4915 CHARLESTOWN ROAD NEW ALBANY, IN 47150

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F 323	Continued From page 11 Res. to put on call light & let staff help her (no date as to when added)." An Admission Fall Care Plan dated January 4, 2011 included, but was not limited to: "Problem/Need Risk of Falls R/T History of Falls Falls Risk Score 12; Plan of Approach: Keep call light and frequently used items in place, non-skid footwear; Assist with toileting; Assess for environmental hazards (clutter) Therapy or Restorative as indicated; Assistive device with in reach @ (at) all times 1/4/11; 1/4/11 Enc (encourage) resident to use call light for assist; 1/4/11 obtain UA (Urinalysis); 1/5/11 Sensor pad to bed & chair at all times" The most recent Quarterly Minimum Data Set dated 12/09/10 lacked a code for the section "Cognitive Skills for Daily Decision Making." During the initial tour with LPN (Licensed Practical Nurse) #4, on January 31, 2011 between 1:20 p.m. and 2:30 p.m., she identified the resident as "confused." In interview with the Director of Nursing on 2/7/11 at 8:40 a.m., she indicated "the resident can use the call light, doesn't use it." 3.1-45(a)(2)	F 323	Director of Nursing/Designee will complete an audit monthly for three months and then quarterly for the remainder of the year to ensure that residents who have been identified as being a risk for falls have been assessed, interventions put into place and care plan updated. Findings will be reported to the QA committee. **4)How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance** program will be put into place? Director of Nursing/Designee will complete an audit month for three months and then quarterly for the remainder of the year to ensure that residents who have been identified as being a risk for falls have been assessed, interventions put into place and care plan updated. Findings will be reported to the QA committee.	3/9/11
F9999	FINAL OBSERVATIONS State Findings 3.1-14 PERSONNEL A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a	F9999		

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F9999	Continued From page 12 tuberculin skin test , using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure employees were screened for tuberculosis at the time of employment or within one month prior to employment. This deficient practice affected 1 of 5 employee whose files were reviewed. (LPN #2) Findings include: During the review of the employee files on 02/03/11 between 10:30 a.m., and 11:45 a.m., the following was identified:	F9999	**1)What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice?** No resident was found to be affected. LPN#2 is no longer employed at the facility. **2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.** Director of Nursing/Designee will complete audit of employees to identify if there are any other employees who were not screened for TB at time of employment or within one month prior to employment for the past year. TB testing will be completed on any employee that may be identified. **3)What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Staff Development Coordinator will be in-serviced on completing TB on all potential employees within 30 days of starting employment.	

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F9999	Continued From page 13 Licensed Practical Nurse #2, with hire date of 10/26/10, lacked documentation of screening for tuberculosis at the time of employment. The last tuberculin skin test was administered 12/27/09, at the place of previous employment. In interview with Licensed Practical Nurse #1, at 12:30 p.m., on 02/03/11, she indicated a tuberculin skin test was not given at the time of hire. 3.1-14(t) 3.1-14(t)(1)	F9999	Staff Development Coordinator/Designee will complete a monthly audit for three months and then quarterly for the remainder of the year on new hires to verify TB testing is completed at time of employment or within one month prior to employment. Findings will be reported to the QA committee. **4)How will the corrective action/s be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Staff Development Coordinator/Designee will complete a monthly audit for three months and then quarterly for the remainder of the year on new hires to verify TB testing is completed at time of employment or within one month prior to employment. Findings will be reported to the QA committee.	3/9/11

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R 000	INITIAL COMMENTS The following state residential deficiency is cited in accordance with 410 IAC 16.2-5.	R 000		
R 217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to develop a service plan which identified and documented the services the facility would	R 217	**1)What corrective action/s will be accomplished for those residents found to have been affected by the deficient practice?** Residential Residents # 4 will have a written service plan implemented and will have their service plan reviewed with the resident and signed by the resident. Unable to correct for Residential Resident #5 due to this individual has been discharged to home. **2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action/s will be taken.** All residential residents will be reviewed to verify there is a service plan in place and has been reviewed with the resident and signed by the resident. **3)What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	

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R 217	Continued From page 1 provide for 2 of 3 residents reviewed for service plans in a sample of 5 residential residents (Residential Residents #4 and #5) and failed to review and discuss the service plans with and have it signed by 1 of 3 residents reviewed for signed service plans in a sample of 5 residential residents (Residential Resident #4). Findings included: 1. Review of the clinical record for Residential Resident #4 on 2/3/2011 at 11:50 a.m., indicated the resident had diagnoses which included, but were not limited to, hypertension, dizziness, gastroesophageal reflux disease, major depressive disorder, and coronary atherosclerosis. On 2/7/2011 at 7:55 a.m., the Director of Nursing [DoN] presented a copy of Residential Resident #4's current service plans in place with review dates of every 6 months, but documentation was lacking as to who would be responsible for providing those services to the resident. Documentation was also lacking to indicate the service plans had been discussed with and signed by the resident. 2. Review of the clinical record for Residential Resident #5 on 2/3/2011 at 9:15 a.m., indicated the resident was admitted on 9/6/2010 and had diagnoses which included, but were not limited to, dementia, hypertension, type 2 diabetes mellitus, peripheral neuropathy. Documentation was lacking of a service plan having been developed to indicate what type of assistance the resident required and who would be providing those services.	R 217	The residential policy on Resident Plan of Care/Service Plan will be reviewed and updated and Licensed staff and Social Services staff will be in-serviced on policy which will include completing a service plan at time of admission, reviewing with resident, and having resident sign the plan. Director of Nursing/Designee will complete an audit monthly and then quarterly for the remainder of the year to verify service plans are in place, reviewed with resident and resident has signed the service plan. Findings will be reported to the QA committee. **4)How will the corrective action/s will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Director of Nursing/Designee will complete an audit monthly and then quarterly for the remainder of the year to verify service plans are in place, reviewed with resident and resident has signed the service plan. Findings will be reported to the QA committee.	

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R 217	Continued From page 2 During an interview with the DoN on 2/7/2011 at 8:37 a.m., she indicated that she was unable to locate any service plans for Resident #5. On 2/7/2011 at 7:55 a.m., the DoN also presented a copy of the facility's current residential policy on "Resident Plan of Care/Service Plan". Review of this policy at this time included, but was not limited to, "Policy: It is the policy of [facility] to identify the care needs of the Residential Care resident and to develop a Plan of Care/Service Plan. Procedure: 1. Upon admission, the resident will have a nursing assessment completed. 2. A Plan of Care/Service Plan will be developed based on this assessment to include all needs identified..."	R 217		3/9/11